APPENDIX G

LIVING WILLS

A BACKGROUND PAPER

Provincial Senior
Citizens Advisory
Council

1985

L I V I N G W I L L S

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L I V I N G W I L L S

I. INTRODUCTION

Formerly death ensued quickly after the cessation of spontaneous heartbeat and respirations. Death was defined as the absence of respiration and pulse and a person was dead when the doctor said he was dead. Advances in medical science and technology now allow heart and lung activity to be maintained solely by extraordinary and artificial means for an indefinite period of time. The determination of the moment of death has become a gray and confusing area as the old criteria are no longer appropriate.

A corresponding development is the ever increasing cost of medical care. In other jurisdictions where the cost of medical care is directly paid by the consumer, the costs of extraordinary measures for a terminally ill person with no reasonable hope of recovery were obvious and prohibitive, particularly when the patient did not wish such measures to be taken. Although these costs are not born directly by the consumer in Canada, the cost of such care nevertheless exists.

The following issues are separate but interwoven with the issue of Living Wills:

1. The right to die;
2. The right to refuse treatment which results in death;
3. The rights of the mentally incompetent adult patient;
4. The criteria for the determination of death;

5. Euthanasia and assisted suicide; and the
6. Civil and criminal liability of health care professionals.

II. LIVING WILLS

A. Definition

A Living Will may be defined as a document wherein a competent adult with no reasonable expectation of recovery from a disability expresses a desire that they be allowed to die rather than kept alive by artificial or heroic means. In general terms a Living Will sanctions the concept of passive euthanasia.

However a Living Will need not merely refuse treatment. This document allows a person to express their desires regarding the course of treatment and the situations wherein that treatment is not desired. Therefore such a document could indicate that that person wishes all means including extraordinary means to be utilized should they become terminally ill.

The term "Living Will" is really a misnomer in that the term "Will" is a document which takes effect at the time of death of the testator. In contrast, the Living Will takes effect during the lifetime of the person drawing up the will.

B. Formalities

A Living Will should be treated in a similar fashion to other wills. The party involved should sign and date this

document. The signatures of two witnesses should be obtained. Copies of the will should be distributed and the whereabouts of the will should be made known to the persons most likely to influence care, such as family and friends, physician, clergyman, and lawyer.

The contents of this will may be simple or complex. This document should indicate the circumstances within which certain treatment will be refused. Additionally such documents usually release health care professionals from liability when following these directives.

C. Status

A Living Will is not a legal document either in Alberta or across Canada as a whole. Health care professionals or institutions are not bound to follow the provisions. It appears that this is a similar situation to the direction in an ordinary will that the testator's body is to be cremated after death. A Living Will provides direction and expresses the wishes of the patient but is not legally binding.

III. ETHICAL CONSIDERATIONS

Various religious opinions indicate that the prolongation of dying by extraordinary means is not supported. This view is evident in the following religious opinions:

Pope Pius XII

"The removal of pain and consciousness by the means of drugs when medical reasons suggest it, is permitted by religion and morality to both doctor and patient; even if the use of drugs will shorten life."

United Methodist Church

"We assert the right of every person to die in dignity without efforts to prolong terminal illnesses merely because the technology is available to do so."

United Church of Christ

"When illness takes away those abilities we associate with full personhood...we may well feel that the mere continuance of the body by machine or drugs is a violation of their person...We do not believe simply the continuance of mere physical existence is either morally defensive or socially desirable or is God's will."

Central Conference of American Rabbis

"The conclusion from the spirit of Jewish law is that while you may not do anything to hasten death you may, under special circumstances of suffering and helplessness, allow death to come."

American Friends Service Committee

"We believe that human life is a gift that is meaningful only as long as the receiver is able to function as a person."

Presbytery of New York City

"We support euthanasia (defined as the refusal to take extraordinary means to preserve life) when one has been reduced to a vegetative existence or is dying of an incurable disease with unrelieved suffering."

The central purpose of the hippocratic oath is one of extending rather than ending life. However various professional and ethical statements support the right to die of the patient. A statement entitled "Joint Statement on Terminal Illness - A protocol for health professionals regarding resuscitative intervention for the terminally ill" was adopted in 1984 by the Canadian Nurses Association, The Canadian Medical Association, and The Canadian Hospital Association. This statement is attached in its entirety at the end of this paper, but the following exerpts are highlighted within:

> "Advances in medical technology are providing health care workers with increasingly sophisticated methods of resuscitation. Although interventions with these devices are often lifesaving, health care professionals often feel uncertain when deciding to resuscitate a patient for whom such an intervention would not appear to be beneficial, in that it would prolong the dying process rather than extend life.
>
> It is recognized that there are conditions of ill health and inevitable death for which an instruction on the order sheet signed by the attending physician that there should be 'no resuscitation' is appropriate and ethically acceptable. It is also recognized that it is the patient's right to accept or refuse treatment."

The above statements support the argument that it is neither immoral nor unethical to recognize the right to die expressed in a Living Will, particularly where the patient is terminally ill and where artificial life support systems are required to maintain existence.

IV. THE LAW

Alberta law arises both in the form of statutory provisions as well as common law.

A. Statutory Law

1. Criminal Code of Canada

A strict reading of the provisions in the Criminal Code of Canada indicate that human life has an absolute value therein. However, it is unlikely that these provisions were intended to apply to situations involving Living Wills. Charges pursuant to these sections in health care settings are virtually non-existent. Nevertheless the existence of these provisions has created a great deal of concern amongst health care professionals and institutions.

The relevant provisions are as follows:

> 14. No person is entitled to consent to have death inflicted upon him, and such consent does not affect the criminal responsibility of any person by whom death may be inflicted upon the person by whom consent is given.
>
> 197. (1) Every one is under a legal duty
>
> (c) to provide necessaries of life to a person under his charge if that person
>
> (i) is unable, by reason of detention, age, illness, insanity or other cause, to withdraw himself from that charge, and
>
> (ii) is unable to provide himself with necessaries of life.

(2) Every one commits an offence who, being under a legal duty within the meaning of subsection (1), fails without lawful excuse, the proof of which lies upon him, to perform that duty, if

(b) with respect to a duty imposed by paragraph (1) (c), the failure to perform the duty endangers the life of the person to whom the duty is owed or causes or is likely to cause the health of that person to be injured permanently.

198. Every one who undertakes to administer surgical or medical treatment to another person or to do any other lawful acts that may endanger the life of another person is, except in cases of necessity, under a legal duty to have and to use reasonable knowledge, skill and care in so doing.

199. Every one who undertakes to do an act is under a legal duty to do it if an omission to do the act is or may be dangerous to life.

202. (1) Every one is criminally negligent who

(a) in doing anything, or

(b) in omitting to do anything that it is his duty to do, shows wanton or reckless disregard for the lives or safety of other persons.

(2) For the purposes of this section "duty" means a duty imposed by law.

205. (1) A person commits homicide when, directly or indirectly, by any means, he causes the death of a human being.

209. Where a person causes bodily injury to a human being that results in death, he causes the death of that human being notwithstanding that the effect of the bodily injury is only to accelerate his death from a disease or disorder arising from some other cause.

212. Culpable homicide is murder

(a) where the person who causes the death of a human being

(i) means to cause his death, or

(ii) means to cause him bodily harm that he knows is likely to cause his death, and is reckless whether death ensues or not;

(b) where a person, meaning to cause death to a human being or meaning to cause him bodily harm that he knows is likely to cause his death, and being reckless whether death ensues or not, by accident or mistake causes death to another human being, notwithstanding that he does not mean to cause death or bodily harm to that human being; or

(c) where a person, for an unlawful object, does anything that he knows or ought to know is likely to cause death, and thereby causes death to a human being, notwithstanding that he desires to effect his object without causing death or bodily harm to any human being.

224. Every one who

(a) counsels or procures a person to commit suicide, or

(b) aids or abets a person to commit suicide,

whether suicide ensues or not, is guilty of an indictable offence and is liable to imprisonment for fourteen years.

Although each of the above provisions could possibly be utilized in situations wherein the provisions of a Living Will were carried out by health care professionals, perhaps section 199, involving everyone who undertakes to do an act, creates the greatest concern.

Health care professionals may be involved in three different scenarios with respect to terminally ill patients. The first alternative is to continue treatment in which case civil or criminal liability will not be attracted when the standard of care is met and contractual duties are fulfilled. However, health care professionals do not have a duty to utilize unusual or heroic measures to preserve life to meet the standard of care.

The second alternative which may arise is that a massive dose of drugs could be given. The second alternative may clearly attract criminal code charges under the above described sections, as well as a civil action in negligence and battery. This alternative is not acceptable regardless of the requests of the patient.

The third alternative is that treatment is not expanded and treatment already underway is discontinued. The third alternative would not likely attract liability in situations where it can be demonstrated that the disease, not the health care professional has caused the death of the patient.

2. Canadian Charter

The Charter enshrines the "right to life, liberty and security of the person", within reasonable limits. The application of this provision to a terminally ill patient seeking

to utilize a Living Will has not yet been tested in Canadian Courts, and therefore its application is unclear. A similar provision exists under the Canadian Bill of Rights which similarly recognizes "the right of the individual to life, liberty and security of the person...and the right not to be deprived thereof except by due process of law". It is unclear whether such provisions would support the right to die principle.

B. Common Law

As a general rule a patient has a right to self determination and the corresponding right to accept or refuse medical treatment. The landmark American decision which has been adopted in various Canadian cases is that of Schloendorff v. Society of New York Hospital, (1914) 211 N.Y. 125, wherein Justice Cardozo stated that:

> "Every human being of adult years and sound mind has a right to determine what shall be done with his own body."

This concept also forms the basis of the doctrine of informed consent. The doctrine of informed consent requires patient consent before medical treatment can be provided. Valid consent requires consent to be given voluntarily, by a person with the mental capacity, that sufficient information be provided, and that the patient know the general nature of the treatment and the persons providing the treatment.

Failure to obtain consent is actionable both in assault and battery and in negligence. In situations where no consent whatsoever has been obtained, an action in assault and battery may be launched. In situations where inadequate information has been provided, a suit may be brought on the basis of negligence, for breach of the standard of care.

The patient also has the right to refuse medical treatment. However the right to refuse treatment becomes unclear when the decision to refuse medical treatment involves withholding or withdrawing life sustaining procedures which may result in death. The exercise of this right may create ethical and legal dilemmas for health care professionals as the preservation of life and health is a professional commitment. However a patient is not legally required to preserve his own life or health, and the health needs of the patient may be quite different than the legal rights of the patient.

When a physician provides treatment which is forbidden by the patient, liability may arise for wrongfully saving life, although the damages would likely be minimal. Unconsented to touching creates the tort of battery. Thus when the patient refuses consent and the doctor proceeds to provide treatment, this touching is unlawful and may give rise both to criminal and civil liability notwithstanding that the decision of the patient appears unreasonable or foolish to the health care professional.

An early decision of the Alberta Court of Appeal held a physician liable when a mangled hand was amputated contrary to the express refusal of the patient, notwithstanding the danger of gas gangrene [Mulloy v. Hop Sang, (1935) 1 W.W.R. 714 (Alta. C.A.)]. Similarly in Beausoleil v. Soeurs de la Charitee, (1966) 53 D.L.R. (2d) 65, the Court held that a physician was liable for providing a spinal anesthetic and obtaining an invalid consent from the patient while the patient was under sedation, when a patient had expressly refused the use of the spinal anesthetic beforehand.

In a recent decision the British Columbia Court of Appeal refused to make an order requiring a woman prisoner to be force fed during a hunger strike (A.G. for British Columbia v. Astaforoff, unreported no. 000942, Vancouver, July 14, 1983 (B.C.C.A.)). As few decisions exist in Canada with respect to the right to refuse treatment which would result in the death of the patient, this area of the law remains unclear. The general principles arising from the above described cases indicate that the right to refuse treatment does exist, although none of these decisions deal with a terminally ill person or a Living Will. As courts accept oral refusals for treatment, it is logical that written refusals in the form of Living Wills would provide evidence of the wishes of the patient sufficient to preclude further treatment.

American decisions involving the right to refuse treatment are based upon a different system of law and a different constitution. The right to refuse blood transfusions has been upheld in American courts in situations where the patient has been fully informed of the consequences of refusal, dependents and minor children are not involved, documents have been executed releasing health care professionals and hospitals from civil liability, and where a clear and present danger to society does not exist. However, these cases involved patients who were not terminally ill whereas the Living Will situation is designed to deal with a patient with no reasonable hope of recovery.

A recent American decision stated that patients have a constitutional right to die, and in that case the right of the patient to make this decision was upheld. It is unclear whether the Canadian Charter of Rights and Freedoms will produce the same results, notwithstanding the sections protecting the right to "liberty and security" of the person and the right to be free from cruel or unusual treatment.

The duty to obtain an informed consent, and presumably an informed refusal of consent, exists with respect to the mentally competent adult. Special problems of determining the competence of patients arise in situations involving incompetent adults, mentally handicapped individuals, and children. In situations where the patient is not mentally competent, further questions

arise regarding which person or persons are legally entitled to make decisions on behalf of the patient. However in the Living Will situation the patient must be mentally competent to execute this document.

In Alberta the Dependent Adults Act makes provision for the appointment of legal guardians for mentally incompetent adults. Legal guardians make decisions on behalf of mentally incompetent adults in various areas including health care, which may extend to the right to refuse treatment. A "durable power of attorney" in which the power of attorney continues after the loss of competence of a person, to my knowledge, does not exist in Canada. The American concept of the durable power of attorney has apparently been adopted in various States to cover the gap between the time at which a Living Will is executed and the loss of mental competence and eventual death of the patient. This ensures that the wishes of the patient are carried out after the loss of mental capacity.

V. RIGHT TO DIE LEGISLATION

The first right to die legislation or Natural Death Act in North America was passed in California on January 1st, 1977. The California Natural Death Act was proposed to protect the patient from unwanted treatment and the prolongation of the dying process, as well as to obviate the need for court applications in

such matters. In general terms this Act allows a terminally ill adult to complete a Living Will within the form prescribed by statute. This Living Will lasts for a five (5) year period and can be revoked by the patient. This Act provides that the withdrawal of treatment is not suicide and does not invalidate life insurance policies. Additionally this legislation protects health care professionals from civil and criminal liability.

Natural Death Acts have now been enacted in approximately one-half of the American States. The California Act has served as the model Act, although the various States contain varying provisions with respect to Living Wills.

This trend has not been followed in Canada. In 1977 in Ontario a Right to Die Bill was introduced as a private members bill. Although this bill passed second reading in the legislature, it did not progress further.

Additionally Bill 242 was introduced in Alberta in 1977 by Dr. Walter Buck. Again, this bill did not go on to become legislation. The current situation in Canada is that Right to Die legislation does not exist in any of the Canadian provinces or territories.

Various problems arise with the legislative solution to the right to die issue. Legal writers as well as the Law Reform Commission of Canada argue that in Canada we already have the

right to die with dignity under the present common law. Heroic measures are not necessary and there is no obligation upon the physician to provide extraordinary measures. The standard of care requires only that reasonable care consistent with current medical practice be provided. Consent to treatment must also be obtained.

A further concern with the legislative solution is that legislation may effectively require a physician to treat unless a legal directive to not treat exists. The onus would then be on every patient to write a formal directive refusing certain types of treatment. This situation would then create the very problem that it was designed to prevent.

A further problem with the legislative solution is that the protection provided must fall squarely within the four corners of the legislation. For example the California Act has been described as being unduly restrictive as it applies only when death is imminent and applies only to withholding mechanical or artificial means to support vital body functions. The Living Will under the Californian Act only lasts five years, and where the will is not renewed, duties of health care professionals are unclear.

VI. RECOMMENDATIONS

Although Living Wills are not legally enforceable

documents in Canada, such documents are instructive in determining the wishes of the dying patient. The considered decision of a mentally competent adult has been reduced to writing and is available to the persons most concerned about the patient after the diagnosis of a terminal illness, particularly after the patient has lost mental competence.

Direction regarding the wishes of the dying patient may be of great assistance to the physician, pastor, lawyer, and family and friends of the dying patient. As a verbal or written consent to treatment is required before treatment can be provided, it is logical that a written document such as a Living Will is a proper basis for respecting the right to refuse treatment of the patient.

The legal status of a Living Will is similar to certain provisions commonly found within an ordinary will that are not legally enforceable. Wills may make reference to the preferred method of burial of the testator, such as cremation. Although this provision is not legally enforceable it provides a written expression of the wishes of the testator to the executor of the will, and therefore it is unlikely that the provision will not be carried into effect.

The greatest difficulty with our current law affecting Living Wills is the existence of ambivalent Criminal Code of

IV. THE LAW

Alberta law arises both in the form of statutory provisions as well as common law.

A. Statutory Law

1. Criminal Code of Canada

A strict reading of the provisions in the Criminal Code of Canada indicates that human life has an absolute value therein. However, it is unlikely that these provisions were intended to apply to situations involving Living Wills. Charges pursuant to these sections in health care settings are virtually non-existent. Nevertheless the existence of these provisions has created a great deal of concern amongst health care professionals and institutions.

The relevant provisions are as follows:

14. No person is entitled to consent to have death inflicted upon him, and such consent does not affect the criminal responsibility of any person by whom death may be inflicted upon the person by whom consent is given.

45. Every one is protected from criminal responsibility for performing a surgical operation upon any person for the benefit of that person if

(a) the operation is performed with reasonable care and skill, and

(b) it is resasonable to perform the operation, having regard to the state of health of the person at the time the operation is performed and to all the circumstances of the case.

197. (1) Every one is under a legal duty

(c) to provide necessaries of life to a person under is charge if that person

(i) is unable, by reason of detention, age, illness, insanity or other cause, to withdraw himself from that charge, and

(ii) is unable to provide himself with necessaries of life.

Canada provisions, rather than the lack of natural death legislation. Matters such as the liability of health care professionals and the application of various sections of the Criminal Code of Canada should be clarified. The Law Reform Commission of Canada has suggested the passage of legislation clarifying that sections 14, 45, 198 and 199 of the Criminal Code shall not be interpreted as requiring a physician to continue to administer or undertake medical treatment against clearly expressed wishes, or when such treatment is medically useless and is not in the best interests of the person, except in accordance with clearly expressed wishes. Similarly physicians should be protected when instituting pallitive care measures and comfort measures when such measures are likely to shorten life expectancy.

In summary my recommendations are as follows:

1. Living Wills may serve useful purposes although they are not technically legally enforceable documents.

2. The Criminal Code of Canada should be modified to clarify the meanings of sections, such as sections 14, 25 198 and 199.

3. Natural death legislation is not required as such provisions may create greater restrictions and difficulties than exist at present.

Groups and associations involved in the issue of Living Wills are as follows:

1. CONCERN FOR DYING
   (formerly known as the Euthanasia Society of America)

   250 West 57 Street
   New York, New York
   U.S.A. 10019

2. HEMLOCK SOCIETY

   P.O. Box 66218
   Los Angelas, California
   U.S.A. 90066

   (213) 391 - 1871

3. EXIT
   (British Organization - address unknown)

4. THE MEMORIAL SOCIETY OF EDMONTON & DISTRICT

   Basement - 7908 - 143 Street
   Edmonton, Alberta

   (486 - 3321)

VII. ATTACHMENTS:

The contents of Living Wills may be as varied as the wishes of the person drafting the will. Various examples of the contents of Living Wills are attached as follows:

1. The Natural Death Act of California, (1977), - Form 1.

2. Euthanasia Education Counsel, New York, (April 1974).

3. "The Living Will", Legal Medical Quarterly Vol. 4, (Spring 1980).

4. Death and Dying - Joint Statement on Terminal Illness A protocol for health professionals regarding resuscitative intervention for the terminally ill. CCH Canadian Limited (1984).

1. The Natural Death Act of California, (1977), Form 1

FORM 1

(The Natural Death Act)

I, ... , being of sound mind, wilfully and voluntarily, direct that all life-sustaining procedures be withheld or withdrawn if at any time I should be in a terminal condition and where the application of life-sustaining procedures would serve only to postpone the moment of death.

It is my intention that this direction be honoured by my family, physicians and medical staff as the final expression of my legal right to refuse medical or surgical treatment and to die naturally.

Made this day of (month, year)

.....

Signature

The person signing this directive is personally known to me and I believe him/her to be of sound mind.

.....

(Witness)

.....

(Witness)

2. Euthanasia Education Counsel, New York, (April 1974)

To My Family, My Physician, My Lawyer and All Others Whom It May Concern

Death is as much a reality as birth, growth, maturity and old age—it is the one certainty of life. If the time comes when I can no longer take part in decisions for my own future, let this statement stand as an expression of my wishes and directions, while I am still of sound mind.

If at such a time the situation should arise in which there is no reasonable expectation of my recovery from extreme physical or mental disability, I direct that I be allowed to die and not be kept alive by medications, artificial means or "heroic measures". I do, however, ask that medication be mercifully administered to me to alleviate suffering even though this may shorten my remaining life.

This statement is made after careful consideration and is in accordance with my strong convictions and beliefs. I want the wishes and directions here expressed carried out to the extent permitted by law. Insofar as they are not legally enforceable, I hope that those to whom this Will is addressed will regard themselves as morally bound by these provisions.

Signed_____

Date _____

Witness_____

Witness_____

Copies of this request have been given to _____

_____

_____

_____

3. "The Living Will", Legal Medical Quarterly, Vol. 4, (Spring 1980)

THE LIVING WILL

TO MY FAMILY, MY PHYSICIAN, MY CLERGYMAN, MY LAWYER: If the time comes when I can no longer actively take part in decisions for my own future, I wish this statement to stand as the testament of my wishes.

If there is no reasonable expectation of my recovery from physical or mental and spiritual disability, I, ————————, request that I be allowed to die and not to be kept alive by artificial means or heroic measures. I ask also that drugs be mercifully administered to me for terminal suffering even if in relieving pain they may hasten the moment of death. I value life and the dignity of life, so that I am not asking that my life be directly taken, but that my dying not be unreasonably prolonged nor the dignity of life be destroyed.

This request is made, after careful reflection, while I am in good health and spirits. Although this document is not legally binding, you who care for me will, I hope, feel morally bound to take it into account. I recognize that it places a heavy burden of responsibility upon you, and it is with the intention of sharing this responsibility that this statement is made.

_____

_____
Witness

_____
Witness

Place, and date

4. Death and Dying - Joint Statement on Terminal Illness. CCH Canadian Limited (1984)

Joint statement on terminal illness

A protocol for health professionals regarding resuscitative intervention for the terminally ill.

This joint statement of the Canadian Nurses Association, the Canadian Medical Association and the Canadian Hospital Association has been developed by a working party of the three associations, in cooperation with the Canadian Bar Association, with the advice of representatives from the Catholic Health Association of Canada and the Law Reform Commission of Canada, and is based on the Statement on Terminal Illness of the Canadian Medical Association. It is intended as a basic, national guideline for use by all those involved in the care of the terminally ill. Individual institutions may wish to develop their own guidelines as an adjunct to the national statement.

Advances in medical technology are providing health care workers with increasingly sophisticated methods of resuscitation. Although interventions with these devices are often lifesaving, health care professionals often feel uncertain when deciding to resuscitate a patient for whom such an intervention would not appear to be beneficial, in that it would prolong the dying process rather than extend life.

It is recognized that there are conditions of ill health and inevitable death for which an instruction on the order sheet signed by the attending physician that there should be "no resuscitation" is appropriate and ethically acceptable. It is also recognized that it is the patient's right to accept or refuse treatment.

Therefore, in the process of caring for a dying patient it may become necessary to consider whether to resuscitate this patient, and the following protocol should be implemented.

1. Clinical criteria

1.1 When the patient's condition is such that a decision should be made as to whether a "no resuscitation" order should be written, that condition should be assessed according to certain clinical criteria.

1.2 Those criteria are the best reasonable estimates made by the responsible physician, and a second staff physician where appropriate, about the following:

1.2.1 the irreversibility of the patient's condition and/or the irreparability of the damage it has done;

1.2.2 the length of time that it can be expected that the patient will live with intervention or without intervention.

1.2.3 the consequences of the "no resuscitation" order, i.e. that it may lead to the death of the patient before the time the physician has estimated.

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2. Procedural guidelines

When the clinical assessment justifies the writing of a "no resuscitation" order, the following procedural guidelines are recommended:

2.1 Decision

2.1.1 the attending physician should assess the patient's competency; unless incompetency is obvious, a second opinion should be sought.

Competent patients have the right to make decisions about their treatment. If the patient so wishes, family members may also be consulted.

When the patient is incompetent, the appropriate member(s) of the patient's family should normally be closely involved in the decision making process.

2.1.2 The opinion of nursing staff caring for the patient should be sought; the opinion of other health care professionals involved may be sought, where practical.

2.1.3 If the attending physician has doubts about the clinical decision, a second opinion should be obtained from another physician. (There may be circumstances in which a lack of time or unavailability of another physician precludes obtaining a second opinion.)

2.1.4 A "no resuscitation" order shall be duly recorded on the patient's record.

2.2 Implementation

2.2.1 The outcome of discussions with the patient and the family, and with the hospital staff, should be recorded in the chart along with their views. The physician consultants should record their opinion as a consultant's note.

2.2.2 The health care personnel involved in the care of the patient should be informed of the decision taken and of the rationale for that decision.

2.2.3 The attending physician and the nursing staff should review a "no resuscitation" order at appropriate intervals.

2.2.4 A request by the patient to rescind a "no resuscitation" order should be implemented immediately.

2.2.5 If there are unexpected changes in the patient's condition, a nurse or another physician may rescind a "no resuscitation" order until the patient's condition can be reassessed by the attending physician.

3. Care of the patient

Palliative care to alleviate the mental and physical discomfort of the patient should be provided at all times.

[¶ 9720] Criteria on the use of no-codes.—The proper use of resuscitative equipment and techniques is not a legal matter. It is a decision that must be made and a standard set by health professionals who are trained in the care of the sick and terminally ill. The law requires only that health care professionals act in an average, reasonable and prudent manner in

meeting this standard, taking into account the circumstances of the individual patient's case. The failure to meet the standard resulting in reasonably foreseeable harm constitutes negligence.

What may be average and reasonable in one situation may be extraordinary or heroic in another in terms of the recognized and accepted standard. Failure to resuscitate a patient who is terminally ill could come within the category of medical negligence. Much depends on the underlying facts and circumstances of the case. If the patient is in the last stages of his illness and there is no hope of him ever recovering from the disease, a decision not to resuscitate may be reasonable and prudent. The same result would not follow from a decision not to revive an elderly person who while being treated for a non-fatal illness, such as a broken arm, experiences a cardiac arrest.

In deciding whether or not to resuscitate a patient, the health care community must set reasonable and prudent standards. It should be done with the knowledge that the law only requires average care, not treatment that is extraordinary. The health professions may set a far higher standard but that is not necessary for purposes of the law.

Taking this factor into account and recognizing that other criteria may be used, the following is a suggested list of guidelines in issuing orders not to resuscitate:

(1) The patient must be suffering from an incurable and unremitting disease or injury without any hope of him recovering from it. It must be certain that the use of resuscitation will not alleviate the patient's condition.

(2) It must be likely that due to his condition the patient will experience an episode of cardiac or respiratory cessation.

(3) The diagnosis of the patient's condition and the likelihood of an arrest must be based upon sound medical judgment.

(4) At least one qualified physician, not associated with the care and treatment of the patient, must confirm the diagnosis and prognosis.

(5) If the patient is competent, his consent to an order not to resuscitate must be obtained. This means that he must be apprised of the consequences of the order, as well as any reasonable alternative means of dealing with a cardiac or respiratory arrest.

(6) The consent of the patient should be documented either in the patient's health record or in an authorization form. The attending physician should also write an entry in the patient's chart indicating that, in his opinion, the patient was mentally capable of giving his consent.

(7) In the case of an incompetent person, the consent to an order not to resuscitate should be obtained from the patient's legal representative. If there is no one standing in this legal relationship with the patient, the order should not be issued unless there is unanimity among the next of kin and this fact is duly recorded. The decision for the incompetent person, including

[The next page is 5259.]

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